



C-Obs 11

Management of the Term Breech Presentation

Background - The Term Breech Trial

The literature is dominated by the large multinational trial of 2088 women with a breech presentation randomised to either planned vaginal birth or elective caesarean section (Hannah et al, 2000). Women with risk factors such as a footling breech, head extension, estimated fetal weight of > 4kg or a suspected fetal anomaly or feto-pelvic disproportion were excluded from the study. Perinatal mortality and serious neonatal morbidity were significantly lower in the planned caesarean section group than for the planned vaginal birth group (1.6 per cent vs 5.0 per cent, $p < 0.0001$). Serious maternal morbidity in the study was 3.6 per cent and this did not differ significantly between the planned caesarean section and planned vaginal birth groups.

A subsequent increase in the use of planned caesarean section for breech presentation at term has been associated with substantial improvements in perinatal outcome in this group of patients, with a halving of the perinatal mortality and even greater reductions in the incidence of birth trauma (Rietberg et al, 2005). However, there remains a view that with the application of strict criteria before and during labour, planned vaginal delivery of the singleton breech at term remains a reasonable option to offer to selected women (Goffinet et al for the PREMODA Study Group).

Recommendations

Diagnosis of a Breech Presentation in the late Third Trimester

All caregivers providing antenatal care should be experienced in palpation of the pregnant abdomen including identification of the presenting part.

Where there is any doubt as to the nature of the presenting part, there should be ready access to obstetric ultrasound to confirm the palpation findings. In most situations, this is best achieved by the presence of an ultrasound machine at the site of antenatal care and caregivers trained in its use.

Where the diagnosis of Breech Presentation has been made late in the third trimester of pregnancy, an ultrasound should be performed to exclude both a fetal congenital anomaly (e.g. late onset hydrocephalus) and hyperextension of the fetal head.

External Cephalic Version (ECV)

Contraindications to ECV may include: caesarean section is indicated on other grounds, oligohydramnios, antepartum haemorrhage, multiple pregnancy (other than after delivery of the first twin), some fetal anomalies, fetal hypoxia, a restrictive nuchal cord, uterine structural anomalies and a uterine scar

ECV should be performed by suitably trained health professionals where there is facility for emergency caesarean section if needed and according to institutional protocols that define the place of cardiotocography, ultrasound and tocolysis

ECV has low complications rates with approximately 0.5% requiring emergency caesarean section. Studies have not been sufficiently powered to estimate the frequency of uterine rupture, perinatal death or long term morbidity but case reports exist of these outcomes

The success rates of ECV are approximately 40% in nulliparous women and 60% in multiparae.

ECV reduces the caesarean section rate although women having a successful ECV have higher caesarean section rates in labour.

Women with a breech presentation at term, and no contraindications to ECV, should be informed about ECV and offered it if clinically appropriate.

Individualise Management

While it is true that women with breech presentation at term will most often be delivered by caesarean section, management should be individualised. The term breech trial did not have the statistical power to meaningfully analyse subgroups, some of which are likely to be pregnancies that do extremely well with breech vaginal delivery.

Factors that may favour a planned vaginal delivery

- 1) Reduced fetal risk from planned vaginal delivery:
 - Continuous fetal heart monitoring in antenatal labour is required.
 - Immediate availability of caesarean facilities if necessary.
 - Availability of a suitably experienced obstetrician.
 - Presumed favourable fetal circumstances, e.g. small or average size, no placental insufficiency, frank breech, appropriate gestational age, documented head flexion.
 - Favourable maternal circumstances, e.g. adequate pelvis, maternal co-operation with pushing, multiparity.
- 2) Increased risk from planned caesarean section:
 - In particular, this would include women planning a large family where a scar on the uterus may have particular serious morbidity in association with placenta praevia accreta in subsequent pregnancies. (Silver et al, 2006).
- 3) Strong particular maternal preference for vaginal delivery.
 - Counselling the patient about the risks and benefits of planned vaginal breech delivery should be undertaken wherever possible.

Management of the Breech Presentation that is first diagnosed in Labour

Although far from desirable, even in the presence of optimal antenatal care, there will still be pregnancies where the breech presentation is first diagnosed in labour.

In determining the preferred mode of delivery in this circumstance, the accoucheur should consider all of the above factors and in addition:

- 1) Whether caesarean section can be effected prior to spontaneous vaginal birth without the need for undue haste that might further endanger mother or child
- 2) Fetal well-being as determined by Cardiotocography
- 3) Increased maternal risks of emergency caesarean section in this circumstance:

- anaesthetic considerations such as non-fasted patient
 - potential technical difficulties delivering the fetus at caesarean section if the breech is very low in the pelvis
- 4) Increased fetal risks of vaginal breech delivery in this circumstance
- Including the possibility of undiagnosed congenital abnormalities or undiagnosed hyperextension of the fetal head

References

1. Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multi-centre trial, Hannah ME, Hannah WJ, Hewson SA, Hodnett ED, Saigol S, Willan AR: *Lancet* 2000; 356: 1375-85.
2. The effect of the Term Breech Trial on medical intervention behaviour and neonatal outcome in the Netherlands: an analysis of 35,453 breech infants. Rietberg CT, Elferink-Stinkens PM, Visser GHA. *BJOG* 2005; 112: 205-9.
3. Maternal Morbidity Associated with multiple repeat cesarean deliveries. Silver RM, Landon MB, Rouse DJ et al. *Obstet Gynecol* 2006; 107: 1226-32.
4. Hofmeyr GJ, Kulier R. External cephalic version for breech presentation at term. *Cochrane Database Syst Rev* 2000.
5. Goffinet F, Carayol M, Foidart J-M, Alexander S, Uzan S, Subtil D, Breart G, for the PREMODA Study Group. Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium. *Am J Obstet Gynecol* 2006; 194: 1002-11.

Links to other related College Statements

[C-Gen 2: Guidelines for consent and the provision of information regarding proposed treatment.](#)

Disclaimer

This College Statement is intended to provide general advice to Practitioners. The statement should never be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of each patient.

The statement has been prepared having regard to general circumstances. It is the responsibility of each Practitioner to have regard to the particular circumstances of each case, and the application of this statement in each case. In particular, clinical management must always be responsive to the needs of the individual patient and the particular circumstances of each case.

This College statement has been prepared having regard to the information available at the time of its preparation, and each Practitioner must have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that College statements are accurate and current at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become available after the date of the statements.